COORDINATION OF BENEFITS QUESTIONNAIRE

Your BCBSD ID Number: _____

A. Do you or any member of your family have other health care coverage? Please check one:

_____ No If no, please check this line, sign this form at the bottom, write in your BCBSD ID number above, and return it in the enclosed postage paid envelope.

_____ Yes If yes, please fill out Sections B and C, then sign this form at the bottom, write in your BCBSD ID number, and return it in the enclosed postage paid envelope.

B. Please fill out this section concerning your and your family's other coverage:

_____ Another Blue Cross Blue Shield of Delaware contract. I.D. Number: _____

_____ Another HEALTH insurer:

Name of the other health insurance company: _____

Name of policyholder: _____ Birthdate: _____

Name of employer: _____

Effective date of policy: _____/_____/_____; if cancelled, date: _____/_____/_____

Names of those covered:

_____	_____	_____
Spouse	Dependent Child	Dependent Child
_____	_____	_____
Dependent Child	Dependent Child	DependentChild

If divorced, who has primary, physical custody? (circle one) MOTHER FATHER

C. Does the other coverage as shown in Section B include a prescription drug program? ___ Yes ___ No

Name of drug plan: _____

We thank you for your time spent completing this questionnaire. The information you have provided will help us process your claims.

Your Signature: _____ Daytime Telephone Number: _____

Mail to Blue Cross Blue Shield of Delaware, Delivery Code 1-5-10, P.O. Box 1991, Wilmington, DE 19899